TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Sentrix Pharmacy & Discount LLC

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-16-1872-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As the insurance carrier took no action within the 45-day period as required by the applicable regulations, the Pharmacy now seeks payment of the claim in full."

Amount in Dispute: $2,289.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier requests that you find no monies are owed to Sentrix Pharmacy & Discount as this medication was not prescribed for, or needed for the compensable injury."

Response Submitted by: AIG, P.O. Box 25974, Shawnee Mission, KS 66225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 18, 2015	Ketoprofen 10%, Amitriptyline 2%, Baclofen 4%, Amantadine 8%, Gabapentin 5%, Versatile Base Cream	$2,289.71	$2,289.71

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out guidelines for medical payments and denials.
3. 28 Texas Administrative Code §134.530 sets out the requirements for use of the closed formulary for claims not subject to certified networks.
4. 28 Texas Administrative Code §134.503 sets out the reimbursement guidelines for pharmacy services not subject to a certified network.

5. Neither party submitted explanation of benefits in regard to the services in dispute.

Issues

1. Did the respondent raise a new issue?
2. Did the carrier process the medical claim per Division guidelines?
3. What is the rule applicable to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier states in their position statement, "The carrier requests that you find no monies are owed to Sentrix Pharmacy & Discount as this medication was not prescribed for, or needed for the compensable injury." Texas Administrative Code §133.307 (2) states,

   Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records:

   (F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

   Review of the submitted explanation of benefits finds insufficient evidence to support the Carrier presented the denial for the disputed services for "not prescribed for, or needed for the compensable injury" prior to the date the MFDR was filed. Therefore, the Carrier's position statement will not be considered in this dispute.

2. The requestor states in their position statement, "As the insurance carrier took no action within the 45-day period as required by the applicable regulations…" 28 Texas Administrative Code §133.240 (a)states,

   An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill.

   Review of the available information finds a completed DWC066 for dates of service in dispute and certified mail receipt showing delivery of document from the health care provider to PMSI/Helios on November 23, 2015. The respondent states in their position statement, "Previous prescriptions have been filled and reimbursements made through TMESYS, Inc." A general search for TMESYS finds, "Tmesys is a registered trademark of PMSI, Inc." The Division finds sufficient evidence to support the medical claim was submitted to the correct carrier however, no information was found to support final action was taken by the carrier. The requestor's position is supported. The services in dispute will be reviewed per applicable rules and fee guidelines.

3. The services in dispute is for the medications Ketoprofen 10%, Amitriptyline 2%, Baclofen 4%, Amantadine 8%, Gabapentin 5%, Versatile Base Cream and are therefore subject to the requirements of 28 Texas Administrative Code §134.503(c) which states,

   The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

The maximum allowable reimbursement will be calculated as follows:

Date of Service	Service in Dispute	Quantity	Amount Billed	MAR ((AWP per unit) x (number of units) x 1.25)
November 18, 2015	Ketoprofen 10% Powder per bottle	24	$250.80	$10.45000 x 24 x 1.25 = $313.50
November 18, 2015	Amitriptyline 2% Powder per bottle	5	$87.55	$18.24000 x 5 x 1.25 = $114.00
November 18, 2015	Baclofen 4% Powder per bottle	10	$342.04	$35.63000 x 10 x 1.25 = $445.38
November 18, 2015	Amantadine 8% Powder per bottle	19	$465.15	$24.22500 x 19 x 1.25 = $575.34
November 18, 2015	Gabapentin 5% Powder per bottle	12	$718.20	$59.85000 x 12 x 1.25 = $897.75
November 18, 2015	Versatile Base Cream per bottle	170	$426.00	$2.50000 x 170 x 1.25 = $531.25
		Total	$2,289.74	$2,877.22

4. The maximum allowable for the services in dispute based on the submitted NDC code(s) and number of units is $2,877.22. The requestor is seeking $2,289.71. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,289.71.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,289.71 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March , 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.